

Report Documentation Page				Form Approved OMB No. 0704-0188	
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1. REPORT DATE MAY 2000		2. REPORT TYPE N/A		3. DATES COVERED -	
4. TITLE AND SUBTITLE EXPERIENCE OF MILITARY NURSE PRACTITIONERS DURING THEIR FIRST YEAR OF PRACTICE				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S) Julie M. Bosch, Capt, USAF, NC				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Uniformed Services University of the Health Sciences				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release, distribution unlimited					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT The lived experience of military nurse practitioners during their first year of clinical experience was explored using a phenomenological approach. The purpose of the study was to explore and describe the experience of the military nurse practitioner during the first year of practice. Purposive sampling of 6 military advanced practice nurses (APNs) was used. Data was generated using open-ended core questions and in-depth face-to-face interviews. Data analysis incorporated the qualitative methods of Marshall and Rossman and Scannel-Desch. Seven theme categories and fifteen theme clusters emerged from the data collected. The theme categories were: nurse practitioner role issues, it s more than they bargained for, control issues, stress and challenges, preceptor stories, patients and practice, and looking toward the future. The data was related to Van Manen s four existential themes. This study is significant to military nursing because very few studies focused on the experience of military nurse practitioners. In addition, transitions have been identified as one of the key concepts central to the discipline of nursing. Recommendations for further study include examining the specific role of the Family Nurse Practitioner, studying the NP role from a physician's perspective, and including Navy NPs in future studies.					
15. SUBJECT TERMS nurse practitioner; role; transition; military nurse; role theory					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT SAR	18. NUMBER OF PAGES 84	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

DISCLAIMER STATEMENT

Department of Defense

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ABSTRACT

The lived experience of military nurse practitioners during their first year of clinical experience was explored using a phenomenological approach. The purpose of the study was to explore and describe the experience of the military nurse practitioner during the first year of practice. Purposive sampling of 6 military advanced practice nurses (APNs) was used. Data was generated using open-ended core questions and in-depth face-to-face interviews. Data analysis incorporated the qualitative methods of Marshall and Rossman and Scannel-Desch. Seven theme categories and fifteen theme clusters emerged from the data collected. The theme categories were: nurse practitioner role issues, it's more than they bargained for, control issues, stress and challenges, preceptor stories, patients and practice, and looking toward the future. The data was related to Van Manen's four existential themes. This study is significant to military nursing because very few studies focused on the experience of military nurse practitioners. In addition, transitions have been identified as one of the key concepts central to the discipline of nursing. Recommendations for further study include examining the specific role of the Family Nurse Practitioner, studying the NP role from a physician's perspective, and including Navy NPs in future studies.

Key Words: **nurse practitioner** **role** **transition** **military nurse** **role theory**

EXPERIENCE OF MILITARY NURSE PRACTITIONERS DURING THEIR FIRST
YEAR OF PRACTICE

by

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Presented to the Graduate School of Nursing Faculty of

The Uniformed Services University of the Health

Sciences in Partial Fulfillment of the

Requirements for the

Degree of

MASTER OF SCIENCE

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH

May 2000

DEDICATION

To the most important people in my life, I dedicate the creation of this thesis. To my husband John, who daily gives me the freedom to work towards my dream and always knows when I need to hit the books. You mean everything to me. To my daughters, Maria and Isabella, who make me laugh and allow me to keep my priorities straight and my feet on the ground. I love you all very much.

I owe this thesis to the military nurse practitioners who shared their personal stories with me. I was fascinated by their experiences, touched by their honesty, and will model their professionalism. They made this research project enjoyable at every turn.

To my wonderful committee chair, Col Martha Turner, and committee members, Pat McMullen and Diane Siebert who gave me warm fuzzies, continual support, and ongoing input from day #1. I thank you all. The three of you are role models for me.

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CHAPTER I: INTRODUCTION: AIM OF THE STUDY

Introduction

The initial transitional year of advanced professional practice is thought to provide the critical foundation on which new professionals build their expertise (Brown & Olshansky, 1997). Identity crisis, a component of role transition, is often experienced as advanced practice nursing students take on the more independent role of the nurse practitioner and transform their traditional nursing roles (Anderson, Leonard, & Yates, 1974; Elkema & Knutson, 1983; Malkemes, 1974; Russell, 1988). As a new advanced practice nurse (APN) there are many challenges to face, and it can be a difficult time of transition. Most APNs have had numerous years of experience as a staff nurse, but assuming the role of an advanced practice nurse presents a host of challenges to the experienced registered nurse.

Background

Graduation from a student role and taking on a new professional role normally constitutes a significant defining point in one's life (Talarczyk & Milbrandt, 1988). Professional development, then, is often defined as a critical life transition for many people, and the transition from student role to that of an APN is an important example of the emergence of a new professional role.

There have been several studies that have explored the role transition of the new advanced practice nurse. In a longitudinal exploratory study conducted by Brown and Olshansky (1997), 35 participants were interviewed at approximately 1 month, 6 month, and 12 month intervals after graduation. The researchers found the initial postgraduate period was a time of identity confusion, during which new graduates experienced

liminality, an anthropological term that refers to being in limbo, being at the border and straddling two identities while not feeling a part of either (Sankar, 1991). Furthermore, an analysis of the data revealed a process of professional development that unfolded during the first year following graduation. This process is reflected in the theoretical model, From Limbo to Legitimacy (Brown & Olshansky, 1997, p. 46). During the tumultuous first year of practice, participants confronted, and subsequently overcame, many obstacles to establishing their new advanced practice identity and had numerous challenges along the way.

Exploring role transition in the military nurse population was of great importance. Military graduate nurse practitioners are being assigned to diverse clinical settings and begin their transitional phase immediately upon graduation. There are several research studies in the literature describing role transition in the civilian setting, but little research exists that reflects a military setting. Military nurses face different challenges than their civilian nurse practitioner counterparts, including additional officer responsibilities and the possibility of deployments to other countries. Exploring the military APN's role transition is vital to ensuring a healthy and mission-ready health care provider. Learning about military nurse practitioner's experiences will benefit military nursing education, and guide further research studies.

Methodology

A qualitative descriptive research approach was used, due to the limited studies found in the literature on this topic. This rigorous, critical, systematic investigative approach has recently gained recognition as a qualitative research approach applicable to the discipline of nursing (Streubert & Carpenter, 1995). Descriptive studies are a means

of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorizing information (Marriner, 1981).

Phenomenology is the qualitative approach that was used in this study. The aim of phenomenology is to describe experience as it is lived by people. One's lived experience is always determined by one's history, and by what Schutz refers to as the sedimentation of all man's previous experiences (1970, p. 23). Lived experience is in a sense layered with meanings that are brought to the relation of being-in-the-world (Munhall & Oiler, 1986).

The objective in phenomenological description is to forage through these layers to rediscover the first experience before we use our knowledge and beliefs to make new sense out of experiences (Munhall & Oiler, 1986). The real, lived experience, is given in the perceived world, and this is what must be described.

Operational Definitions

For the purpose of this study, the following definitions were used:

Role. Behavioral repertoire characteristic of a person or a position; a set of standards, descriptions, norms, or concepts held for behaviors of a person or social position; or a position itself (Biddle, 1979).

Transition. A point of reference from which a person's life course takes a new direction requiring adaptation or change in restructuring behaviors and roles appropriate to the new direction this new direction in the life course also requires change in responsibilities, goals, identity, and feelings about one's self in general (Mercer, Nichols, & Doyle, 1989).

Role transition. Processes of change that are lasting in their effects, force one to give up how one views the world and his or her place in it, and necessitate the development of new assumptions and skills to enable the individual to cope with a new altered life space (Parkes, cited in Murphy, 1990, p 87.).

Military nurse practitioner. A Navy, Army, or Air Force Nurse Corps officer and Registered Nurse who has completed a formal NP program, acquiring additional knowledge and skills and has assumed a legitimate role as a primary health care provider within the military beneficiary population. The role includes health status assessment, provision of care, instruction and counseling and collaboration with other health care providers. Preparation in the provision of care in combat situation is an additional requirement.

Role theory. A large body of literature related to social behavior and both the overt and covert mechanisms that shape it (Hardy & Conway, 1988).

Statement of the Problem

Meleis (1975, 1985, 1986, & 1991) has proposed that transition is one of the concepts central to the discipline of nursing. Transitions are accompanied by a wide range of emotions, many of which attest to the difficulties encountered during transition. Any transitional process appears to have three identifiable phases that can be documented, namely those of challenge , confusion and adaptation (Hill & Macgregor, 1998).

Broome (1991) argues that because it is a psychological process the transition experience is often misunderstood or seen as a problem in the clinical area, as the individual is perceived as less effective than they were in their old role . It was critical,

therefore, to explore factors that described the initial role transition so that appropriate interventions can be designed to support new military NPs in their quest to develop the knowledge and skills to provide the highest quality of care possible (Brown & Olshansky, 1997). Thus, the problem lies in the lack of current research available regarding the experiences of military nurse practitioners during their first year of practice.

Statement of the Purpose

The purpose of the study was to explore and describe the transitional experience of the military nurse practitioner during the first year of clinical practice.

Research Question

The research question for this study was: What is the experience of military nurse practitioners during their first year of practice?

Assumptions

The following assumptions were, in part, adapted from Munhall and Oiler (1986).

1. The investigator turned to a phenomenon which seriously interested her and committed her to the world. The experience was investigated as it was lived.
2. Military nurse practitioner experiences are different from civilian nurse practitioner experiences.
3. All nurse practitioner graduates are practicing in a clinical APN role.
4. Recent graduates will have more insight and memories to share with the researcher.
5. Tri-service experiences are similar in APN graduates, therefore, their first year of clinical practice will be similar.

6. All participants had previous experience as military nurses so the experience was that of a clinical role transition, not of a military role transition.
7. Participants will provide honest responses to the investigator s queries.

Limitations

1. The investigation was limited to the descriptions of the nurse practitioners who participated in the study.
2. Gaining the stories of APNs overseas was not possible, therefore, these additional perspectives were not included in these descriptions.
3. The investigation was limited by the APNs descriptions of their experiences during their first year of clinical practice.
4. The research interviews took place in the Washington, D.C. metropolitan area, thus APNs who practice in rural areas and smaller clinics were not interviewed.

CHAPTER II: BACKGROUND: EVOLUTION OF THE STUDY

Introduction

The purpose of this chapter was to clarify and highlight the phenomenon of role theory and role transition. Care was taken to keep the literature from influencing the investigator during data collection and analysis. Selected for this review were several topics; role theories, role transitions, APN educational components, and the initial year of APN clinical practice. The literature review described what was present in the civilian community and illustrated that similar research is lacking in the military setting.

Role Theory

The formation of role identity is a complex process. As Stryker (1980) pointed out, each role identity has two aspects: the conventional and the idiosyncratic in varying proportions. And as he has further observed, individuals are faced with the problem of devising perspectives that allow them to maintain their views of self, to legitimate their role identities (p. 120).

The health care system is one of the most rapidly expanding and complex systems in today's society. Because of both the exponential increase in technology that has occurred within an extremely short time, and the expansion of the health care system itself, attempts to cope with related role changes have been identified as major stressors (Hardy & Conway, 1988). One example of a recently evolved professional role is that of the nurse practitioner, a role also referred to as the expanded role of the nurse (Andrews & Yankauer, 1971). Given what seems to be a momentum toward still further role realignments within the nursing profession and the total system of health care delivery, it is assumed nurses are still undergoing similar altered role functions and relationships.

For health care providers such as nurses, the principal domains utilizing role theory include the client, nursing actions, and environment (Kim, 1983).

When an individual enters new roles and exits from old roles that have been incorporated into the structure of the self, one's sense of enduring identity is disturbed (Murray, 1998). Role exits, as well as role entrances, are closely related to self-identity because the roles an individual plays in society become part of one's self-definition (Ebaugh, 1988). Therefore, elements of the new or previous role have to be negotiated and reintegrated into one's self-concept before stability and security can be reestablished.

When a social structure creates difficult, conflicting, or near-impossible demands for occupants of positions within it, the general condition can be identified as one of *role stress* (Hardy & Conway, 1988). As persons move from old roles into newly developing roles, that is, as they engage in the process of role transition, role stress is likely to arise. Whether it is seen as desirable and part of a challenge or as undesirable and something to avoid or minimize will be influenced by the social and cultural definitions that develop around the new roles. Therefore, it was imperative that further research be conducted regarding the ever-changing advanced practice nurse role definitions to reduce role stress.

Role Transitions

To exist is to change, to change is to mature, to mature is to go on creating oneself endlessly. Henri Bergson, French Philosopher, cited in (Bridges, 1991, p. 44).

Expectations are other subjective phenomena that collectively influence the transition experience (Imle, 1990). People undergoing transition may or may not know what to expect, and their expectations may or may not be realistic. When one knows

what to expect, the stress associated with transition may be somewhat alleviated (Hollander & Haber, 1992).

A prominent theme in many articles (Battles, 1988; Chielens & Herrick, 1990; Loveys, 1990) is the importance of resources within the environment during a transition (Schumacher & Meleis, 1994). The presence of a supportive preceptor, mentor, or role model has been identified as an important resource during professional transitions. Preceptors facilitate clinical role transitions and an experienced teacher/mentor can smooth a transition by serving as a guide, role model, and sounding board (Grady, 1992).

Transitions are accompanied by a wide range of emotions, many of which attest to the difficulties encountered during transition. Several writers have noted that stress and emotional distress can occur during transition, specifically: anxiety, insecurity, frustration, depression, apprehension, ambivalence, and loneliness. They discovered that more emphasis has been placed on the process of transition than on the identification of factors which indicated a positive transition outcome. Schumacher and Meleis (1994) have identified three indicators of healthy transition that appear relevant across all types of transition: (a) a subjective sense of well-being, (b) mastery of new behaviors, and (c) the well-being of interpersonal relationships. Mastery may occur early in the transition for some and later for others; thus the assessment of these indicators is appropriate periodically throughout the transition and not simply at the end of the transition period.

The most important indicator, it would seem, for a healthy transition to an APN role is role mastery. This denotes achievement of skilled role performance and comfort with the behavior required in the new situation. Mastery has several components, including competence, which entails knowledge or cognitive skill, decision-making, and

self-confidence (Alex & MacFarlane, 1992). Mastery is indicative of successful transition at the organizational as well as individual level.

Preparation for transition is a nursing therapeutic that is widely discussed in the literature (Schumacher & Meleis, 1994). Education is the primary modality for creating optimal conditions in preparation for transition (Kane, 1992). Adequate preparation requires sufficient time for the new graduate to assimilate new responsibilities and implement new skills.

At the organizational level, undesirable transition outcomes include lack of cohesiveness, increased absenteeism and turnover, rumors, suspicion, an increase in fighting, a decrease in cooperation, resignations, and failure to recruit and retain new people. On the other hand, cooperation among staff, effective communication, teamwork, and trust reflect a healthy transition (Losee & Cook, 1989). Realizing the differences between the two outcomes is critical, especially in the military where success is based on teamwork. This research study gathered information about the experiences of military APNs during their first year of practice and offered valuable insight into their transition outcomes.

APN Educational Components

The first formal programs to prepare professional nurses as primary health care providers began as continuing education programs in the mid-1960s (Hupcey, 1990). Despite the passage of over 20 years and many changes in APN education, Roberts, Tabloski, and Bova (1997) support the original concept of the epigenesis of the nurse practitioner role as identity crisis, as proposed in the original paper by Anderson and colleagues (1974) still exists today. Exploring the educational preparation for APNs

offered the researcher insight into how the graduate student NP is socialized into a new role.

Russell (1988) analyzed journals kept by 50 adult nurse practitioner graduate students. The resocialization process from nurse to nurse practitioner was conceptualized as one involving discovery, creation, definition, modification, and eventual incorporation of the new emerging role into the self concept. These early studies were significant and led to the development of role courses to provide anticipatory socialization experiences during nurse practitioner programs to ease the transition for students.

In a similar study, Roberts and colleagues (1997) described six years of experience working with graduate nurse practitioner students who experienced a transitional process similar to the epigenesis described by Anderson and co-investigators (1974). From observations and written journals of more than 100 graduate nurse practitioner students, Roberts and associates identified three specific areas of transition: (a) clinical competence; (b) role confusion; and (c) conflict with preceptors and faculty. Furthermore, the participants consistently described feelings of anger, incompetence, and role confusion at certain points in the program. Content and experiences regarding role transition are considered essential components for a successful NP program. These researchers believe that exploring the role transition of the NP would be helpful to faculty and clinical preceptors in understanding and assessing student development.

Strategies suggested to enhance understanding the role transition APNs will invariably experience include: a) anticipatory guidance at the start of each semester and b) discussion of clinical cases in lieu of lectures to learn to appreciate the range of acceptable approaches to clinical problems (Roberts et al., 1997). Educating the student

about the developing NP role and preparing him/her for a role transition during the challenging first year of practice should be a part of every NP curriculum. However, role transition needs to be understood more fully before the educational component is unconditionally accepted and integrated into programs nationwide.

Nursing has recognized the significance of mentoring, particularly in nursing education. Hayes (1998) researched a mentoring model of clinical education that represented a longer-term commitment for preceptors than usual precepting arrangements. She studied eastern philosophical principles to provide a framework for examining mentoring as a strategy for promotion of self-efficacy for advanced practice. The extent to which NP preceptors mentor their students may impact on student self-efficacy, the development of role competence, and potential patient care outcomes.

With an extended investment in students, the outcomes attributed to mentoring can occur, especially adequate socialization into the advanced role practice and the development of self-efficacy for practice (Hupcey, 1988). Mentoring is a factor in promoting self-efficacy, for it is the mentor who recognizes the potential of the novice, instills confidence through belief and trust, and offers the individual being mentored opportunities for new experiences (Holloran, 1989).

Hupcey's (1988) study, a national survey of 94 final semester, graduate-level adult nurse practitioner students, was undertaken to determine if they were being socialized into the role of a master's prepared nurse practitioner and to identify factors which seemed to influence this socialization process. Using Biddle's (1979) role theory as a framework, the study demonstrated that graduate students may not be adequately socialized into the role of a master's prepared practitioner during their graduate school

experiences. Recommendations were made to evaluate graduate school curricula and strengthen the clinical experiences of the students.

Roberts and co-researchers (1997) consistently observed anxiety, anger and feelings of incompetence and role confusion in their graduate students at certain points in their program. They hypothesized that this process had to do with taking an expert and asking them to be a novice again. This is certainly true with experienced military nurses who continue on to an APN program. If they can be taught to understand the role of an APN and the subsequent transition process while they are still in school, their transitional phase should be markedly improved.

First Year of APN Practice

Research has shown that entry into a new professional field is highly stressful during the first year (Klaich, 1990). Such transitions are particularly difficult for clinically oriented professionals, who immediately feel tremendous responsibility for making decisions about people's health (Brown & Olshansky, 1998).

Brown and Olshansky's 1998 study of 35 APNs revealed NPs' *initial* stress stemmed from recuperating from school, negotiating the bureaucracy, looking for a job, and worrying about the future. Slowly throughout the first year post-graduation, the participants shifted their focus and gained confidence, while increasing their clinical competence. By the end of the first year of practice, NPs were able to broaden their perspective and affirm themselves, aware of the substantial progress they had made during the difficult first year.

Shea and Selfridge-Thomas (1997) documented their transition from registered nurses to APNs in an article titled, *The ED nurse practitioner: Pearls and pitfalls of role*

transition and development. The authors found similar challenges to those Brown & Olshansky's 1998 subjects experienced. They stated, what transpired, as we made our role transition, were unexpected feelings of uncertainty and questioning of our abilities (Shea & Selfridge, 1997, p.235). They discovered that their confidence in previously mastered knowledge and skills did not guarantee an easy transition to the role of an NP.

The purpose of Oermann and Moffitt-Wolf's (1997) study was to describe the stresses, challenges, and threats experienced by new graduate registered nurses (RNs) in clinical practice during their initial orientation period and examined the relationship of social support to these stresses. Thirty-five graduate nurses completed a modified Pagana Clinical Stress Questionnaire and social support measure during their orientation period. They were clear about factors that facilitated their learning, the need for consistent preceptors during orientation who supported and guided their learning in clinical practice. The findings of the research suggest preceptorship and internship programs are important in the orientation of graduate nurses.

Today's health care climate, where the legitimacy of advanced practice nurses has been called into question by sometimes hostile, challenging colleagues or a nonsupportive practice environment, make it imperative to reduce the vulnerability of new APNs (American Medical Association, 1995). This literature review discussed primarily civilian APNs, their transition phase and first-year challenges. Little has been studied about the transition a military APN experiences as they graduate from school. It was, therefore, critical to conduct this qualitative descriptive study to investigate the experiences of new military APNs during their first year of practice.

Chapter III: METHOD OF INQUIRY

Introduction

A descriptive, exploratory approach was used to address the researcher's question: What is the experience of military nurse practitioners during their first year of practice? A qualitative approach was chosen to enable the researcher to gather a rich description of the lived experiences of the participants.

A definition of qualitative research can be stated, as involving broadly stated questions about human experiences and realities, studied through sustained contact with persons in their natural environments, and producing rich, descriptive data that help us to understand those persons' experiences. The emphasis is on achieving understanding that will, in turn, open up new options for action and new perspectives that can change people's worlds (Munhall & Oiler, 1993, pp 69-70).

Qualitative Research

The qualitative approaches to research are based on a world view which is holistic in nature and has the following beliefs: (a) There is not a single reality. Reality is based on perceptions and thus is different for each individual and changes over time; (b) What we know has meaning only within a given context or situation (Burns & Grove, 1997). Furthermore, the qualitative approach is interactive, holistic, dynamic, evolving, primarily inductive, and descriptive. It focuses on perspectives, uniqueness, and the participants' subjective lived experiences. (Mariano, 1993).

Qualitative research enables examination of a much broader scope of dimensions and experiences than is usually possible with quantitative research. However, nursing interest in qualitative research is fairly recent, having begun in the late 1970s and

significantly increasing in the 1990s. The very nature of the qualitative research design promotes the understanding of human experiences, because it allows the participant to tell their story. Since human experiences and emotions are difficult to quantify, qualitative research is often a more effective method of investigating emotional responses than is quantitative research (Burns & Grove, 1997). A description of the phenomena under investigation can allow greater understanding, and thus better control of nursing practice. Here, the units of analysis are words, rather than the numerical values found in quantitative studies.

Burns and Grove (1997) describe six approaches to qualitative research used in nursing: phenomenological, grounded theory, ethnographic, historical, philosophical inquiry, and critical social theory. These approaches are very different. A phenomenological approach was used for this study both as a philosophy and a research method because the purpose of phenomenological research is to describe lived experiences. Colaizzi (1978) states that the questions a phenomenological researcher asks in an interview are successful to the extent that they enable the person being interviewed to regain the experience of the phenomenon being explored.

Before data collection began, the researcher identified beliefs, assumptions, and preconceptions about the research topic. The researcher then bracketed these preconceptions. Bracketing is suspending or laying aside what is known about the experience being studied (Burns & Grove, 1997). This helped the researcher avoid misinterpreting the phenomenon as it was being described by the participants.

Research Process

Sample Selection

A purposeful sample of six military nurse practitioners was interviewed.

Purposeful sampling ensured the interviews resulted in rich and varied descriptions, and further illuminated the research question. The researcher sought permission from local military Chief Nurses before interviewing their nurse practitioners. Participants met the following criteria:

1. They graduated from an accredited nurse practitioner program within the last four years.
2. They were able to recall and share their experiences.
3. They were willing to participate in the study.

Intensity sampling was used to provide participants who may have had an intense first year of clinical experience. These advanced practice nurses were referred by other APNs who knew of their particular extreme experiences. Finally, snowball sampling was employed. Snowball sampling identifies cases of interest from people who know people who know people who know what cases are information-rich (Patton, 1990). These people would be good examples for the study and good interview subjects. This strategy was used when the researcher found a few subjects meeting the necessary criteria. The researcher then asked them for their assistance in getting in touch with other APNs that shared similar characteristics (Burns & Grove, 1997).

Data Collection Procedures

First contact with the participant was initiated by the researcher. The researcher called the potential participant, explained the study and the applicable informed consent

considerations. When interest was expressed by the APN, they were included in the sample. The next point of communication was by mail. Each participant was sent a consent form to be signed. The informed consent confirmed the appointment time and place agreed upon for the interview.

The interview was conducted according to the participant's choice of environment and thus took place primarily in the offices of the APNs. The need for interpersonal engagement and for approaching the research situation holistically by conducting interviews in participants' familiar surroundings was identified by researchers as important to successful interviewing (Drew, 1993). For each interview, the researcher's goal was to establish a quiet, non-threatening atmosphere thus optimizing a trusting relationship between the participant and the researcher.

Interview Process

At the beginning of the interview, the purpose of the study was reviewed with the participant. The signed consent form was co-signed by the researcher. Confidentiality was discussed and assured. The participant was given the opportunity to ask any questions clarifying the interview process and purpose of the research study. The interview was tape-recorded and consisted of open-ended questions.

1. Tell me about your experience as a first year nurse practitioner.
2. Tell me about a particularly significant event.
3. Tell me about an adjustment you made.
4. What kinds of challenges did you face?

One of the challenges of interviewing in phenomenological research is finding ways for participants to get into immediate touch with their experience, the thoughts and

emotions involved, and to communicate it (Drew, 1993, p. 346). The researcher made every effort to allow the participant to feel comfortable during the interview

Rapport was enhanced between the participant and the researcher by active listening, periods of silence when appropriate, and a trust between the two individuals established by careful preparation for the interview. Drew (1993) claims the interviewer's engagement with a participant depends, at least in part, on how he or she is perceived by the participant. An interview is more likely to be productive if the interviewer is perceived as nonjudgmental, sensitive and ethical so that the participant will feel comfortable sharing thoughts and feelings. Care was taken throughout the initial contacts and interviews to establish this trust.

The participants were asked broad questions during the interview and encouraged to take as much time to formulate his or her answers as they needed. Reflective and sometimes probing questions were used to enrich the description of the story and to focus the interview. The interview began with the research question and additional core questions were frequently added to guide the interview and assist the participant.

The interview ended when the participants expressed they had nothing further to share. Participants were encouraged to contact the researcher following the interview if they thought of additional stories or experiences they wished to share.

Data Analysis

Data analysis is the process of bringing order, structure, and meaning to the mass of collected data. It does not proceed in a linear fashion and it is a search for general statements about relationships of categories of data (Marshall & Rossman, 1989). Within two days following the interview, the researcher listened to the tapes and made notations

for future analysis. The researcher listened carefully to voice tone, inflection, and pauses of both researcher and participant, as well as to the content. The words were transcribed verbatim, excluding ah and ums , as well as the participant s name and any other self-identifying information. As noted by Burns and Grove (1997), once the interview is transcribed, the transcript will take on an independent reality and become the researcher s raw data.

Burns & Grove (1997) explain tapes contain more than words; they contain feeling, emphasis, nonverbal communications. These are at least as important to the communication as the words (p 532). Marshall and Rossman (1989) and Scannell-Desch (1992) suggest the following strategies for data analysis.

1. Organize the data. All audiotape recordings were listened to several times to gain familiarity with the feeling and tone. All of the transcripts were transcribed by a professional medical transcriptionist. Each transcript was read and re-read in its entirety by the researcher to foster further intimacy with the data. Subsequent readings were done using a highlighter pen and significant statements were highlighted.
2. Generating themes and clusters. The researcher identified recurring ideas or language, and salient themes. Data was studied until theme categories emerged. Theme categories were synthesized into theme clusters. Clustering is the process of sorting elements into categories or groups (Burns & Grove, 1997). The clusters which emerged were organized and documented on a poster boards. Theme clusters were further synthesized into metathemes, when these became apparent.

3. Testing the emergent categories and clusters with the data. As categories and clusters emerged, the themes were compared with themes from the previous participants transcripts to ensure the meanings were consistent. Care was taken to ensure the themes that emerged were consistent with the written transcripts.
4. Searching for alternative explanations. As categories and clusters emerged from the data, the researcher engaged in the critical act of challenging the very pattern that seemed so apparent. Thus, the researcher searched for and described alternative explanations for emerging themes.
5. Writing the report. The results were integrated into a description of the lived experiences of the APNs using the four existential theme categories as outlined by Van Manen (1990). The theme categories, theme clusters, and metathemes were reviewed by the researcher s committee for validation. Findings were shared with the participants and consenting Chief Nurses via a letter.

Trustworthiness

Trustworthiness necessitates the achievement of four objectives: credibility, transferability, dependability, and confirmability (Munhall & Oiler, 1993). These terms are equivalent to the well-known terms reliability and validity utilized in quantitative study. Credibility refers to the truth value or believability of the findings. Peer debriefing took place during conferences with APN instructors who were experienced with advanced clinical practice and the experiences of a new APN.

Transferability allows someone to decide whether the conclusions or findings can be transferred to another context (Munhall & Oiler, 1993). This was accomplished by providing a detailed data base and a detailed description of the phenomenon.

Dependability, or consistency, is established when the researcher has enough examples from the text that the reader can validate the findings. The researcher, the research advisor, and the committee were in agreement that sufficient data was gathered to support the themes of the experiences.

The final construct, confirmability, captures the traditional concept of objectivity. Confirmability attests that the conclusions and recommendations are strongly supported by the data and that there is congruity between the researcher's interpretations and actual evidence. This was largely accomplished by the use of an audit process (Munhall & Oiler, 1993).

Human Rights Considerations

Permission was obtained from The Uniformed Services University of the Health Sciences Institutional Review Board as well as the Corp Chiefs from The United States Air Force and The United States Army. The human rights considerations consisted of informed written and verbal consent and confidentiality of materials. Anonymity was ensured by presenting data in aggregate form so individual subjects were not identified. The interview setting and time were chosen by the participant to ensure confidentiality and honest responses to questions.

CHAPTER IV: STUDY FINDINGS

Findings of the Study

This chapter will present a description of the sample and the results of data analysis. The findings include theme categories and interpretive theme clusters. There are seven theme categories with theme clusters falling into most categories. Below each theme category is a short summary of the participants' responses that follow. Each theme cluster has significant statements following from the participants' transcribed interviews. The findings of this study are presented in the following list to illustrate the experiences of the military nurse practitioners during their first year of practice.

Description of the Sample

The sample consisted of six participants, three Air Force nurse practitioners and three Army nurse practitioners. All the participants were women. Three of the participants were Family Nurse Practitioners, one was a Women's Health Practitioner and two were Pediatric Nurse Practitioners. The average length of the participants' experience was two years. There were two lieutenant colonels, three majors and one captain interviewed. Rank emerged as a theme cluster and it was obviously an issue specific to the military nurse practitioner.

Theme Categories and Theme Clusters

Theme Category 1: Nurse practitioner role issues

Theme Cluster 1A: Nurse practitioner role

Theme Cluster 1B: Educating others about the NP role

Theme Cluster 1C: Communication

Theme Cluster 1D: Role adjustment

Theme Category 2: More than they bargained for

Theme Cluster 2A: Politics

Theme Cluster 2B: Does rank have its privileges?

Theme Cluster 2C: Dual-hatted woes and perks

Theme Category 3: Who's in control now?

Theme Cluster 3A: Decision making

Theme Cluster 3B: Control of schedules

Theme Category 4: Stress and challenges

Theme Cluster 4A: Long/exhausting clinic days

Theme Cluster 4B: Steep learning curve

Theme Category 5: Preceptor stories

Theme Category 6: The patients and the practice

Theme Cluster 6A: Patient care issues

Theme Cluster 6B: Scope of practice

Theme Category 7: Looking toward the future

Theme Cluster 7A: Advice for new nurse practitioners

Theme Cluster 7B: Paving the way for the next generation

Theme Category 1: Nurse practitioner role issues

The nurses learned early-on there is a real difference between the medical model traditionally used by physicians and the nursing model that often shaped their nursing

careers. Several expressed difficulty fitting into their new provider peer-group versus the well-known nurse group as they sought to find their own niche. This was complicated by perceived barriers between the NP and the Nurse Corps. The Nurse Corps always familiar territory to a registered military nurse was now playing a different role in the life of an NP. In their new role, some felt ostracized and separate from their nursing peers.

All of the nurses spent a great deal of time educating patients and physicians about their role; its boundaries and its unique nursing component. Most NPs took the time to explain their role to patients during clinic visits, some developed a brochure on their unique role, and others educated the public en masse during community programs taught by NPs. Every NP felt some degree of frustration when they realized very few people truly understood their scope of practice.

Dealing with physician personalities took on a whole new meaning for some NPs, while others thoroughly enjoyed working side by side with Family Practice physicians who often shared their holistic idea of medical care. Others discussed a new professional relationship between the medical technician and the NP that differed from what they previously experienced as a registered nurse.

The first few days as a new nurse practitioner were remarkably clear in the minds of all of the participants. Some felt like a fraud, others felt intimidated, and others went home feeling exhilarated at their accomplishments. Most described feeling overwhelmed and unprepared for their new role, and one NP had to take on the additional role of a preceptor during her first three months.

Theme Cluster 1A: Nurse practitioner role

I noticed in staff meetings, clinically, they [the physicians] were very sharp on the medical point but I was always the one bringing up the psychosocial factors. Does this patient have a living will? What's the support? After about a year and a half, they finally got a Ph.D. Sociologist into that residency program and I was invited to the ethics panel, mainly because of the way the nurses look at things.

I was ostracized cut off from the Nurse Corps. My name wasn't on any e-mail group for nurse managers. I wasn't in the loop for information. Initially, I didn't realize, I was too busy getting the skills needed to survive. I wasn't invited to any meetings and I wasn't used to that, having always been in the thick of everything. That hurt after awhile. It hurt me in career brief in terms of what was going on in the Nurse Corps. After a year of ventilating to the higher ups, my name was eventually added and so I am in the email groups now. I'm in the loop. That was an adjustment. I was politically out of the loop and it hurt.

I approached it in a civilian light, I'm here to help you. I stayed after clinic to help them [physicians] out. I did their difficult patients. If they were pulling their hair out over this 80-year old that ate up their 15-minute slot, I'd say, I'll take Mrs. B. You go do what you want to do. That's my job — to do what you don't like to do. And that is how I sold myself. And I took their panel when they went down ...to do their OB rotation. They came back and I gave them a beautiful briefing on every patient of theirs I saw. And they just loved it. Absolutely, because they were residents and nobody ever gave them briefings. Here is this lieutenant colonel who made you feel great; treats them like a god. It worked to my advantage. I went in there saying, What can I do for you?

It was wonderful. Those Friday mornings were pretty consistent. In addition, when somebody was out sick or we knew somebody was going to be on leave, sometimes I could carve out time to go do well-child care in the well-baby clinic. That was nice too. It was great. I loved it. I chose the right role. I'm not worried about that. I love the teaching element.

If I had to do it over again, I was glad I was sent to a family practice residency where there's a lot of FP docs. The FP docs have a view of the world that matches with the Family Nurse Practitioner holistic, family-oriented, and that was very helpful.

You spend a lot of time feeling like you're constantly validating your worth and that's a challenge, rather than just being able to have them look at you as colleague and get on with it.

Theme Cluster 1B: Educating others about the NP role

We got a new head nurse right about my first year. A very dynamic person. He told me off the bat, I don't know what you do. Tell me what you do. So, I had to go up there and explain things to him.

Bottom line, from an organizational point of view, no one knew the difference between a PA and a Family Nurse Practitioner. It was brand new. They didn't know how to utilize us in the organizational chart. The FP docs had never worked with an FNP. They expected the brand new FNP graduates to be technically expert like a PA. A PA has residency and rotations whereas the FNP coming out of school may have seen so many patients or so many hours of clinic but didn't have a residency. They didn't know what we were capable of and organizationally, they didn't know where to fit us and how to use us.

I have to educate all the internists on what an FNP can do. So, that's going to take me six months. They're a little leery: It's some lieutenant colonel. What do I do with her?

The beauty was I was with the family practice residency. I had three years of residents; 10 in each class — 30. I trained literally 30 residents plus about ten or more staff physicians on what an FNP can do. And now they're spreading out now. Now, they know how to use me if they get one. How to use you.

The medical director and element leader was a board-certified internist and the first question is Well, what can you do? The military, particularly the Air Force, knows all about physician's assistants and they're familiar with the women's health nurse practitioner but they're not familiar with family nurse practitioners because it is relatively new. My response is pretty much what a physician's assistant is all about with a different twist because of 19 years of nursing experience. I do a lot of education and prevention as part of the nursing component. There are differences but to a physician that is really hard to get into right away. I think over a period of time they will notice the difference.

I spent a lot of time telling the docs in the primary care clinic, I don't do this. This is not within my scope of practice. I spent a lot of time educating about the role because so many people don't know. They thought I could do a lot more. No way. I can do about 85% of what a pediatrician does. I am not a pediatrician. I'm not all of a sudden going to know this 15% because we don't have a pediatrician. I can't do it all.

The most important I learned in grad school was the role definition; how to say, no, this is not within my scope. I spent a lot of time doing that. They just didn't know.

Do a lot of educating on your own. A lot of people don't know, and not just the patients. That's a given; they're not going to know. They'll call you doctor 20 million

times — it doesn't matter how many times you say it — they'll call you doctor. If they walk out your door and someone says, Have you ever seen a nurse practitioner? They'll say, No. Even though I tell them, they say they're seeing a doctor.

Providers and other medical people you're working with, they don't know what a nurse practitioner is. I had pamphlets on what a pediatric nurse practitioner is I kept telling people over and over just getting out in the community and doing a lot of teaching. We did education nights with parents — a lot of young parents. Just get out there and be visible and do say you're a nurse practitioner so the role gets more visibility.

Theme Cluster 1C: Communication

I gained 20 pounds, got very depressed, got anxious, got to know myself really well by the end of that first year. With what I call difficult physician personalities preceptors I had to deal with — and there were two in particular that everybody avoided — I got a real good soul-searching and basically ended up, after eight months of suffering with this guy, confronting him and saying he was difficult to deal with and that I found it a shame that I couldn't learn more from him. I appreciated his qualities but there were certain characteristics that made me feel bad and it was just blocking my learning. I gave him some examples. I didn't cry when I talked to him but it was pretty close. I didn't show him my weakness or anything because I knew he would have jumped on me. After that confrontation, I learned more from that physician than I learned from him the previous eight months. And I learned after that, more of myself. From now on, if that happens, I know how to deal with it.

Learning how to get along with the technicians is another challenge. It's a fine line being a friend to the techs you work with. A lot of times, you are assigned a single technician and you don't want to be a hard boss. You want to get along with them but at the same time, you can't. You have to keep the professional level. I don't think they appreciate providers that are not professional. They're going to be a lot more professional with you than you're used to. It's Ma'am this and Captain this and it's kind of different.

I think standing up to the doctors and becoming more assertive was my biggest challenge. That is something I've always had to struggle with. I'm passive. I let people walk all over me. If I had to do it all over again, I wouldn't have done it that way. For my preceptorship, I would have said a lot sooner, You're not giving me what I need. If you're not planning to do that, I need to have someone else.

Some of the docs said We need to start seeing 10-minute patients. I said, I am a nurse practitioner. I am not a doctor. I am going to see my patients for 20 minutes. You can do whatever you want. No one ever bothered me. They didn't want to see me upset and they left me alone.

I had to learn about being more outspoken because I'd find myself fighting for this clinic a lot. Pediatrics tends to get the whatever's left over from the budget. The active duty patients, of course, got the most of it, which I understand. But if your kid is sick, you're not going to do your job well. This is important too. I felt I had to do a lot of speaking up for our clinic. I became a lot more outspoken.

When your scope of practice is about to be surpassed you need to say, No, I'm not going to do this. Find someone else. People will try and make you do more. Either they're ignorant and don't know or they just don't want to be bothered with this particular patient. You do have to stand up for yourself. It's your right.

Theme Cluster ID: Role adjustments

I think the biggest part of the adjustment was just for being an expert to not being

Probably the hardest adjustment I had to make was going from being a very experienced peds nurse with 13 years of experience and being the person that people came to with questions because you had all the experience. They thought you had all the answers and I guess I thought I did too most of the time — usually I did — you know I knew what I was doing and I am really comfortable in the role and I had reached Benner's expert and BOOM! You're back down at the bottom! Well, not completely the bottom because you're not completely a novice because you know nursing and you've gone through school but I certainly was back in an advanced beginner role.

Both of us (another NP graduate & I) came out so backwards in our technical skills. We had such a low self-esteem and we were meant to feel that way because we didn't even match the third-year medical students sometimes in their skills.

It was very intimidating. I remember arriving at my first base. I went in to meet the charge person of the clinic and they said, Okay, you start on Thursday. I hadn't even had house-hunting time or anything but they were not aware of that. It was obviously a communication mix-up. From that point on, I was scared to death. I went down to meet with some education coordinator at the hospital and I started crying. That was how I started out.

You just go in and introduce yourself to the patient — Major _____, Nurse Practitioner, what can I do for you today? You almost feel like a fraud. Like what do I know, I don't know anything. You really don't think you know anything but you really do. You really, really do.

You take everything you were taught in school. You do a good history and you do a good physical and then leave the patient, tell him to get dressed and that I would be

right back. And then I would go back into my office and look it up and then you go back in and tell them what you think and what you're going to do and every day gets easier.

The first day you had to talk to your preceptor a few times and then you do your records and you have a 100% record review when you first get out there. At the end of the day, they'd give you some feedback which is great. And then you go home feeling really proud of yourself that you made it through your first day.

I saw 12 patients today all by myself and I knew some stuff and some stuff I didn't. I had to look up a lot of things and then everyday just gets easier. The next day, you ask a few less questions. You might have had a few repeats, like sinus infections or something simple and it just gets easier. We did weeks of that, and then I was ready to move up to a quicker pace and you tell your element chief. I moved up to a combination of half-hour and some twenty-minute appointments and before you know, you're doing full clinics. And, that's watched too. So, you can't just sit back and be lazy because then the rumor gets out. Well, the PAs come in and they go right up to twenty minutes in three weeks. The nurse practitioners take six months. So in the military we're on trial. We're still new.

The day I hit the door, I saw 18 patients. I was not assigned a preceptor. I wasn't introduced to the complete staff. I knew who my boss was. Wasn't given time to orient and felt completely overwhelmed. In fact, I wanted to quit. I said, I don't want to do this. I originally went back (to grad school) to get out of administration so that I could take care of patients and I thought being a nurse practitioner was the way to go. I'd say, my first month, I was having nightmares about whether or not I was killing patients. Needless to say, it was traumatic. Very traumatic.

I didn't feel prepared. I felt school prepared me on a theoretical basis more than a clinical basis and if I had not been a nurse for 21 years, I know I would have killed somebody. My first week I diagnosed an atypical appendix that had perforated in a kid and I was not trained to treat that as a nurse practitioner. I only knew because I had been a surgical nurse. I did not feel prepared and I was completely overwhelmed. I wanted to quit.

Just coming to work was a challenge every day. I would go home and had a long drive it was like an hour, and I would think about, what lab should I be drawing? I need to call this patient

In the first three months, I had students. I had students! What do you want me to do with these students? Nurse practitioner students. First three months on the job. I said, I can't teach these kids. I don't know anything! But, it turned out to be a positive experience. We both learned because they were back in that academic greenness, so they brought me information and I taught them the little bit that I had gained. This is what you need to know in order to take care of patients

Theme category 2: More than they bargained for

Several NPs faced political stumbling blocks their first year. Some wanted to work in the Emergency Room but discovered that was the territory of the PAs. Most NPs worked in a family practice clinic or internal medicine clinic. Other NPs did not want to be perceived as a threat to their peers and tried not to become too popular for fear of being resented by their peer group.

Rank became an issue for the more senior officers, as they were seasoned nurses and brand new graduates at the same time. Overall, the senior ranking new graduates felt more pressure to perform competently than the junior officers. Many of them were also dual-hatted, working as a provider in the clinic and as the Officer-In-Charge of the unit. This usually added to the stress of their daily clinical work as a nurse practitioner. They had to adjust to their new role and gain clinical competence while juggling enormous responsibilities as the leader of a busy clinic.

Theme Cluster 2A: Politics

The challenge, basically, was not to be too popular in the Family Practice Clinic where I would outshine some of the residents. I had to tiptoe very carefully and make sure I dotted all my I's and crossed all my T's. I had to be very careful not to be too popular. The other nurse practitioner wanted to be empaneled. And they quickly got rid of her out of they put her on a team in primary care because they saw her as a threat to the residents. I tried to tone down that threat.

Picking up your clinical skills was easy after six months, it was the political stumbling blocks that first year. It might have been peculiar to my class because it's the first AFSC and brand new, but I made sure I was non-threatening.

I just had to be politically careful and it paid off. I got everything I wanted. If I wanted any kind of training, anywhere, I could still probably get it.

The ER in this place is the province of the PAs. I broached that to the higher ups saying that it would be a perfect cradle to grave experience for a Family Nurse

Practitioner, working the fast track clinic. No, that's the PAs. So I backed off. You know you have to learn how to do that.

Theme Cluster 2B: Does rank have its privileges?

Most of the FNP's in my class, and me in particular, outranked most of the docs. That contributed to the organizational stress.

A lot has to do with rank. I would have been the highest ranking in the ER and overshadowed the ER director and everybody else and they felt uncomfortable. If I didn't have so much rank, it would be all right. But, it also helps this gray hair helps. It gives me authority and legitimacy. They think I know everything. And so, basically I let them think that. I do know a lot of organizational that pulls them out of the water. Their ego is stroked when I say, Oh, I didn't know that.

I was a major a senior major coming up on lieutenant colonel, so some of the normal stresses of being a new provider and a little bit unsure and inexperienced, coupled with the rank and people's or my perceived expectations that other people have of me because of my rank. When you walk through the door patients see you're an officer, I think people assume a certain amount of experience with that and rightfully so. But here you are a major, soon to be a lieutenant colonel. Now a new graduate. That, for me, was a little bit unnerving.

I was in an environment with physician's assistants in the rank of lieutenants who knew their stuff and here is this major nurse practitioner. I think rank makes a difference. The clinic was set up for an internal medicine residency program, PAs and me. I really felt the burden of I ought to be really good.

I think rank makes a difference. I don't think I would be as pushed if I was a lieutenant.

You can't let rank get in the way. You just can't and I think some people do. I have had a chance to work with people who have rank and you just have to put your lab coat on over the rank and just be a nurse practitioner. The PAs put their lab coats on and the doctors put their lab coats on and they do it well.

Theme Cluster 2C: Dual-hatted woes and perks

A lot of times, I felt like I was on this incredible see-saw because when I was on the ward as the head nurse, I was back in that comfortable experienced role people looked at me as the expert. People came to me for consultations and the residents would come in and ask me questions. But then you threw me down in the clinic as an NP with that same group of residents and I'm asking them. Our roles were totally switched. That was a big adjustment.

At first, I had 20 minute appointments and that's what the provider before me did. I adopted that because that worked out real well. When I just started, the first couple of months, I would always leave a 40-minute gap. I'll see patients and leave a gap to catch up because I was so slow and just starting. I was able to just do that. No one was there to say no because I was running the clinic as well as seeing the patients.

My first year as a nurse practitioner, the facility I went to decided the best training was to make me Head Nurse of the inpatient pediatric ward. So, as an appeasement, they said, We'll let you carve out whatever time you can in the pediatric clinic. Luckily, the chief of outpatient peds was a guy who did his residency with me. So, I knew him. And he was my preceptor. And we set it up that Friday mornings, which tended to be the quietest day on the ward, at 7:30 if my staffing on the ward was good, they would open same-day appointments for me. In the winter, when I could get down there my appointments would fill up and I would have a full morning and it would be great. Other times I might see two patients. That was my first year.

One of the biggest challenges was the dual role. Patients didn't understand when they saw me in clinic as an NP and then later their child got admitted, they saw me on the ward as the head nurse. They were very confused.

Occasionally, something would happen and I would get a phone call in the ward and hear, one of our practitioners is out sick. Can you come cover clinic? And I would go with my whites on. The patients were looking at me saying, You don't dress like everyone else. Am I seeing a nurse practitioner or are you just a nurse? How do you respond to the just a nurse comment? That was a challenge. The dual role was certainly a challenge.

I was the only officer in the clinic. I was also the OIC of the clinic. So, I ended up making my own template.

The politics running the clinic and seeing the patients. Now you have to juggle both. It got a lot easier once I got a real strong head nurse on board.

When I took over as Head Nurse, we opened the pediatric observation unit 24 hours a day and we were doing respigam for the high-risk preemies. That counted toward my practitioner time because these babies had to have, not a complete physical, but a going over when they would come in every four weeks to make sure that they were healthy enough to get the medication. I did those physicals. I wrote the orders for their medication. That was the most concentrated part of being a practitioner during those two years because I did it for two years, three days a week. So, while I'm doing head nurse duties, I'm also in charge of what goes on with those kids. Sometimes actively giving the respigam, but always being the one available if somebody started reacting or had any problems.

Theme Category 3: Who's in control now?

Several participants expressed feeling alone even in multi-provider clinics, as they adjusted to their new responsibilities. It was often intimidating making those first decisions on their own, worrying constantly that they were making the right ones. There was a pull that the NPs felt between saving the patient from harm if they missed something clinically significant and facing ridicule from their peers if they overtreated. Many NPs came from a flexible management/administration nursing background and adjusting to their somewhat rigid schedule of back-to-back patients was a monumental stress factor. They described a real loss of autonomy, with very little time to call their own.

Theme Cluster 3A: Decision making

I had a patient come in and this little girl had a huge lymphadenopathy in her groin, a big mass, hard, red, indurated. The little girl was Vietnamese and so were the parents and they didn't speak much English. I guess her Dad was active duty but he was deployed so her mother and grandfather had come. What's this big mass? All of a sudden, I'm in this big quandary because it's the first time I'd ever felt like I was really alone to make a decision. If I made the wrong decision and this was the worst thing I could think of, some cancerous growth and I made the wrong decision, could this child die? But, if I overreacted, was I going to get a lot of grief for that? It was a really weird feeling because I truly felt, in this huge pediatric clinic, with 32 physicians, not counting the residents, that I was all alone. Looking back I know I wasn't. All I had to do was call Infectious Disease or a pediatric infectious disease person that was my collaborating physician. But, for an half an hour or an hour, I was a basket case and I got further behind because I didn't know what to do. I learned a lot of important lessons that day.

Probably the most intimidating thing was just seeing patients on my own. Throughout my clinical student rotation working with a preceptor, she really didn't let me interview patients or function on my own. She was constantly holding my hand and basically doing all the interviewing. So, when I got out on my own, I was truly thrown into the frying pan.

Cluster 3B: Control of schedules

The biggest adjustment was the fact your schedule is pretty much theirs and they control your life. You think twice if you're sick. You say, Well, I've got a whole line of patients. So, I better come in. I remember on many days working when I felt horrible. The biggest thing is you have to be your best every day. You can't have a bad day where you say, I'm not in the mood for people today. You have to just put on a show that you're there for them and even if they're the last patient of the day on a Friday afternoon and you're ready to go home, you have to be there for their needs.

The scheduling was a little bit better because as a floor nurse, you were competing with about 15 other nurses for vacation time and you had to put your name in the book way in advance. Whereas they would allow a couple of providers to be on vacation at the same time. In our clinic, there were four doctors, two nurse practitioners and a couple of midwives. So, they'd allow a couple to go on leave at the same time.

I don't remember working through my lunch every day. I've always taken a lunch break. That happened to a few classmates that said, I worked through my lunch and I took work home at night. I never did that but I did spend a lot of time on callbacks at the end of the day.

From early on in my career, I had that nurse manager role Monday through Friday. Autonomy. Meaning, I could go to lunch, I could go run at lunch. I had about three years in the military as the 12 hour shift staff nurse on a ward before I fell in the nurse manager Monday through Friday schedule.. I had that for about 16 years. Then I became a nurse practitioner. Now, the biggest adjustment for me was I walk into the clinic in the morning and they hand me my schedule of 28 patients for the day. I felt like I was a staff nurse again. I felt like I had no control. My first patient was at 7:30. My last patient was at 16:30 and you go to lunch in the middle. That was the biggest adjustment for me was the loss of autonomy. I could not go to lunch when I wanted. I could not run when I wanted. I was not in control of my schedule. Therefore, I was not in control of my life. I could not just put in a leave slip whenever I wanted because I have patients scheduled. I could not make my doctor's appointment whenever I wanted. It really was for me like being a staff nurse again where, when you're on that ward, you're it and you cannot just go to lunch or run or whatever you want because you have your patients. That was very, very hard and I didn't like it.

The biggest thing for me to overcome was the loss of autonomy. If you have a Chief Nurse that says, Would you like to be the Flight commander? Well, I could do that standing on my head because I have a Master's in Administration. That's a ticket to get freedom back into your schedule because if I take that job as Flight Commander, I can say, I will see patients just two days a week. All of a sudden, I get my autonomy back. I can go to lunch when I want and then I'll only have Tuesdays and Thursdays. It's very attractive but I didn't allow it to happen to me. No. No. It was too easy to do that and I am afraid that a lot of people will do it. I'm afraid a lot of people do it.

Theme Category 4: Stress and challenges

The NPs worked long days their first year with short lunch breaks, constantly struggling to finish their charting and go home to their families and their busy lives.

They shared similar feelings of fear and uncertainty when they treated patients during the initial months. They worried if they would know how to treat the acute patient walking in their door or if they would always have the right answers.

Many of them were unpleasantly surprised to find that the difficult learning was just beginning as they started to see patients and make decisions on their own. Some felt embarrassed when they had to look information up in reference books and many thought that the learning curve was now a straight upward line.

Theme Cluster 4A: Long clinic days

I mostly grabbed a sandwich at five till one before 1:00 sick call and then you're already exhausted and fatigued starting out your afternoon but you pretty much finish up your afternoon, finish up your charts and you go home and you feel good because you saw all your patients. You might have run a little bit behind but you did all your charts and you're done and so I think when you come in the next morning your desk is clear and you start a fresh day. Some of the people don't do that and they bring their records home. See, but when I went home. I would go home to my family.

It's two years now into the role as of June. It's two years. I still come in here and wonder if I've done the right thing and I thought that I was the only one feeling this way because we don't get to talk to our colleagues enough because we are so busy taking care of patients. But come to find out that my counterpart, has been a nurse practitioner for 20 years, and she is retiring, and she said to this day, she still is fearful of killing somebody.

To this date, my patients call me at home. I worry about them that much and I think that's why I'm in such burnout. To make sure that things have been followed up on. Did you go back to the doc? What did the doc say to you? Now, what are you going to do? So, it's a challenge every day coming in here because you don't know what's going to walk through that door. You have absolutely no idea.

I trained for the marathon to get the stress out. It was like one extreme to the other. I knew what I could do. It really was a challenge. I went from the lowest of the low in terms of not having any self-confidence in my skills and my intuition. I had to learn from scratch and then learn how to trust myself until the point where okay I learned from this. Let me go with my lifelong learning experience and take it from there. What can I do to improve myself?

One of the worst things at that time was putting in long days and reading and everything. Fourteen hours a day. Coming home, getting tired, not having time to exercise, eat properly. So, my goal was to do a marathon and I did it. I accomplished it and it paid off. And occasionally I slide back into bad habits but I figured it was a good time in my life. I survived it. So, I know I can survive anything that they throw at me.

It was a long day. You saw your whole stack of patients and then you got on the phone and you took care of a whole bunch of them on the phone.

I could not continue to do this through the years. People say that they've been a practitioner for 20 years oh no. I am taking another job as a Commander. I've done this for two years. It's taught me a lot and I will keep my hands in it. I will still see patients one day a week but doing this full-time? No. I choose not to do it. Yes, I've had doctors tell me, You're better than some of our residents. Now, did that make me feel good? Yeah, in the sense that they trusted my judgment and they trusted my competence, but does that make me want to continue? No. No, because I don't want to have to come to work every day wondering or doubting. I just don't choose to do it but it's been an excellent, excellent learning experience.

You have at the end of the clinic day, you have additional things to do. You can't just say, I'm done for the day. I'm going home. You have a lot of resentment for the technicians. They don't see that side of your role and they leave at 4:30 every day and go home with a clear conscience. I remember many times being the only one in the clinic. It's 5:30, 6:00 at night but that gets better with time. You get more efficient and you get out of there quicker. It's a hard adjustment.

Theme Cluster 4B: Steep learning curve

The first year was learning. The first six months you're learning all kinds of stuff you'll never learn in school. You just have to do it. And after about six months, I can say I was really comfortable doing it. I knew when to say, Okay, this is way beyond my scope of practice. I need to call somebody in. Of course you're uncomfortable. You don't know much, so it's like Well? Is this something I should know? Or is this something I should send away? So, you just have to learn.

The whole learning curve I mean, it's just not the same what you do in school and read in the book. I spent a lot of time in the books just trying to get things to match with this real-life patient.

It was nerve-racking in a way because, you come out of school and you'd like to believe that you learned everything you needed to know and you didn't. You know the learning curve isn't even a curve when you come out of school. It's a straight upward linear line. But, it's fun and I was in a very supportive environment.

It was really funny because I would put my books in the office next-door and I would say, You know, I'm just going to go check on someone. I would be running next-door. I would be looking stuff up because I didn't want to look I didn't want to say to the patient, I don't know. Let me look that up. It was a long time before I felt comfortable enough to say to a patient, You know, you have me stumped. Let me go turn some pages in a book. And, the first time I did it, I thought, Oh, this person's going to think I'm an idiot. And, you know they responded just fine. So, then I felt a lot more comfortable doing it.

You felt like you had to look everything up and my first month of doing clinical, they had been really good and they'd carved me out a little extra time so that the ward was really well staffed. We'd overstaff so that I could spend a little more consistent time in clinic. But charting I had sticky notes all over these charts. I'd be charting and I'd have one sticking up that was my subjective and another was my objective and nothing charted on the piece of paper. And if somebody said to me, Oh, and I need to take the record with me. I'd say, Oh my God! I wanted it to look so perfect. No markouts probably because I knew somebody was looking at it.

I still felt like a student and that my notes were getting graded. So, I had sticky notes everywhere. I learned to chart from the bottom of the chart up when I would do things like that because then I would subjective just a little bit — their chief complaint, and then I would go down to the bottom and write my plan so I could remember what I told them. And then after they left, I could fill in the in-betweens. So my O and my A frequently got left until after the patient's gone. Then my entire lunch hour, I went charting getting my charts done or the end of the day.

We're all in the same boat as far as not feeling like you know enough. If you ever get to that point and you feel like you know everything, then you're in the wrong business. Then you need to get out because then you're just starting to become sloppy.

Theme Category 5: Preceptor stories

Every new nurse practitioner, ideally, has a preceptor and/or a mentor. Every participant had a vivid story about their preceptor, good or bad, supportive or not. One NP was allowed to set up her own one-year residency to facilitate her training while

another could not get her preceptor to review her charts at all. The NPs' responses make it very clear that the preceptor serves as the bridge between a struggling new graduate's early days and a confident provider emerging at the end of the orientation period.

Theme cluster 5A: Preceptors

There was one other nurse practitioner and she has since become a really good friend but at the time, I didn't like her. She was not supportive. She was one of those, 'Here's your office. If you have any questions, let me know.' She was also my sponsor but she didn't really give me a lot of day to day support. The main support I did receive was from the technicians and the nursing staff.

We had a six-month preceptorship under a physician and the person that I was assigned to was a guy who had never had experience with Nurse Practitioners and he was very young and cocky. He really didn't understand our role at all. He didn't know how to be a preceptor. He didn't know what I needed and I don't think he really cared. We had to do a chart review — a 100% chart review — and he would put it off as long as he could until the last possible minute and I'd say, 'We've got to do this chart review. I really need some feedback.' It was like pulling teeth to get him to give me any feedback. So, he was actually fired from that job four months into it and I got another preceptor who was a midwife and gave me a little bit more feedback. Originally, I was blamed because I wasn't assertive enough. Eventually, they saw the light and said, 'No, this guy does not have an interest in being a preceptor because it's a big role. It takes time.'

It could have been a lot smoother but I guess a lot of people get that same experience. They get thrown in there and it really depends on who happens to be at your clinic. You're at the mercy of who you work with and if you work with good people, you're probably going to have an easier time than working with people that don't understand your role or really have other agendas. The other Nurse Practitioner, I felt, was burned out. She was teaching students every single day and so I was looked at as another student coming in instead of a coworker. I think that's why she didn't give me a whole lot of support.

I knew my preceptor and he knew my strengths and my personality. In a way I was precepted the entire time I was there, though, certainly I could make some decisions on my own. They were pretty good there about saying, 'You know, for the first three or four months, let's just kind of keep you protected and you can come and ask me questions.' And he audited every single one of my charts for about the first three months. So, he had to sign off on everything and then after he felt that I was competent to do things on my own, then I was fully credentialed.

There was one significant event it was being trained by the docs on how to brief them or present a case their way, like a basic medical student learns how to present a

medical case, whereas in my class we really never did get what has to be included or how to brief a case in a minute or less. And that's what their expectation was. So, that was one humiliating factor. I didn't let them humble me too much but it was hammered home to me and to my cohort. It took us a good month to get that down pat.

It is a new AFSC and brand new role and I had no one to mentor me except maybe a few sympathetic FP docs who had what I call the mother-maternal tendencies.

The person I was replacing was also a PNP and she took me under her wing. She was older. She was a lieutenant colonel and she took me under her wing and showed me the ropes of the clinic — how the clinic runs. I worked with her for about a month and then she PCSed and it was the doctor and me. He was excellent as far as a preceptor goes. Loved to tease. Loved to talk. That kind of person. So, it was a great experience. I learned a lot from him too. They weren't assigned as my preceptors; I was just kind of lucky. She took me under her wing and him, I just kind of hooked onto was able to call him whenever I had a question.

My other counterpart was, how shall I say, not willing to share. She was very threatened because of the fact she didn't have a degree and I didn't know that at the time. She was very, very hung up on that. I didn't care. She was very knowledgeable. I don't care paper doesn't make you. But she didn't share. She didn't want to share. Anything I'd ask her, I'd have to drag it out of her. You've got to have a mentor. Someone that's willing to take care of you because I think that's important.

They set me up with somebody that I knew, an internist that I had worked with years before when I was a nurse, and she was supposed to be my preceptor and her office was next door to mine. They set me up on half-hour appointments just like a physician's assistant and they set you up with about 12 patients a day and luckily, I had my own office and exam room.

Theme Category 6: The patients and the practice

Positive feedback from patients was always welcomed and valued and served as a turning point. It was perceived by the NPs as establishing their clinical competence. The scope of a nurse practitioner's practice was often a source of confusion for patients and physicians alike and the NPs found themselves taking care of extremely complex patients, not at all what they expected. The physician-extender role seemed to be an illusion or an unkept promise as the NPs were pushed to see patients often outside their scope of care.

Theme Cluster 6A: Patient care issues

I remember getting a call from a lady that I had done an exam on and she was thanking me for referring her to dermatology because she had a melanoma on her back. I think I was fairly new when that happened and it really just sticks with you. You tend to dwell on all the negative things we as nurses, beat ourselves up a lot on the things we don't know and that we didn't do and forgot to do. We don't emphasize the positive. That's when I think the job transitions from fear into really liking what you're doing when you start getting the feedback from the patients; when they start requesting you again or giving you positive feedback or you hear positive surveys come back or they said, "Oh, I like that provider." That's when it really starts and that's one thing you don't really get a lot in the first year because they don't know you as much. You have to establish your name. You have to do your time before you become a provider who is requested. I think it takes time.

I tell my patients, "Look, if you're out there in the civilian sector and you're going to see a nurse practitioner, you ask them, 'How long have you been a nurse?' because I really think that's important. If I hadn't been a nurse for 21 years, I would have missed a lot of this stuff because it's a basic instinct that you have, 'Look, I know something's wrong here. I can't put my hand on it.'

I learned so very much about the medical model. Had that nursing model down pat but the medical model an invaluable learning experience. I did have moments where I felt I really made a difference. Of course, that's when the patient would call you and say, "I feel great. You cured me. Now that I felt good about. Did that happen quite a bit?" Yes. I'd always have patients that would come back. They would hunt me down. I couldn't even go to the bathroom without these patients running after me. So, those were the rewarding moments but they're not rewarding enough for me to continue to do this.

Theme Cluster 6B: Scope of practice

And, we function as physicians. We function as residents. We see more patients than the residents. We get more complex patients than the residents. The good thing about it, though, we do have physician backup but a lot of times you have to wait for that backup. Like right now, up here, I don't have physician backup. I have to go all the way down to the internal medicine clinic, which I had to do this morning, to see the doc on call. So, we're very, very isolated and, I'd say, practicing independently. You can pick up the phone, if you can get through right then and there. When your patient is in distress and you're getting a busy signal, it isn't very conducive to patient care.

I had a nurse in dialysis — a head nurse. Kept complaining about abdominal pain. I am one of these paranoid practitioners, I'll order everything in the book and then some until I can find out what's wrong with my patient, then send it to the physician because it's out of my scope. They couldn't find a thing. Said, "It's all in his head." In and out of

the ER. Nothing. So, I finally said, Forget this I'm going to get an MRI. I'm going to do a CAT scan, all this stuff. Guess what he had? A complex liver cyst, a padded cyst that was so complex, it had grown so much, it had incorporated his aorta and that's why he was having chest pain and, although it was not a metastatic tumor, it grew like one. They had never seen it before. So they took him to surgery. Then he developed atelectasis and a whole bunch of other complications post-op. He almost died. So, this was about three months worth of workup back and forth. Physicians telling him it's all in his head. So, they finally told him, Yeah, if we hadn't we? We, meaning ME — if the nurse practitioner hadn't pursued this, you would have died. The only reason I pursued it was because something told me something's wrong with this man. He kept saying, I don't feel good. I don't feel good. I keep reminding my boss that was not in my scope of practice, complex liver cysts. I don't do those.

I get all these little old people who get attached and they don't want to go see a physician because when I send them to a physician, the physician just doesn't give them that holistic kind of comprehensive nursing care. Then they don't follow up. And then they come back to me all messed up again. I say, Look, that's out of my scope. I don't do that. They don't want to hear that. They say, but you can fix me. No, I can't fix you. That's why I sent you to the physician. So the physician can fix you. Well, he didn't fix me. So, I want you to fix me. So, I'm constantly talking to the doc, What do I do with this? What do I do?? This is out of my scope. What do I do with it? It's frustrating and I'm not going to continue to do this.

My biggest adjustment? The realization that this isn't what I thought it was going to be. I thought the nurse practitioner role I envisioned it as an extender of a physician, as a collegial-type of teamwork and I would be the teaching component. A couple of physicians, they referred their diabetics to me, their hypertensives, for normal follow-up care.

I just had a patient in now. The physician can't even manage him. Blood sugar's are anywhere from 55 to 400. That is not a normal diabetic. So, I just didn't envision this type of practice. Now, if I had one little physician, like an endocrinologist or rheumatologist, and I can become that subject matter expert, now that would be fine but don't give me all this other. Patients come here and I have to work them up from head to toe for dizziness, for acute abdominal pain. Uh uh. That's doc stuff. That is not nurse practitioner stuff. So, I think we lost the focus of the scope. I know that scope with acute care, it's being broadened and that's fine, but I'm not acute care and I'm not functioning in an acute care role. So, therefore, I'm not taking those kinds of patients. I didn't receive that kind of training. I didn't come up here to do this.

Health promotion, disease prevention — That's what nurse practitioners are about or should be about. Yes, and we do have our nurse practitioners that want to be junior docs and I think they're very, very dangerous.

I'll tell physicians when I call them, I'm a nurse practitioner. I am not a doc but I know there's something wrong with this patient. I can feel it. I said, Here's the workup I've done and I know it's not comprehensive but you tell me what to do and I'll do it and then you follow-up on this patient because this is out of my scope.

Theme Category 7: Looking toward the future

Every nurse practitioner was happy to share advice with future new graduates to ease their transition. Although it was never directly solicited, the NPs wove it into their responses, desperately wanting to share their early mistakes and tips. The advice varied, ranging from charting more efficiently, to the best kind of first assignment; the importance of really listening to the patients, to never forgetting you are a nurse first; how to learn from PAs and how to best manage your time. These participants want to help pave the way for future generations of nurse practitioners to be successful.

Theme Cluster 7A: Advice for new nurse practitioners

What I told students is the best way to do it if you are really running behind is leave little sticky notes on your charts and put all the main things that you want to remember for that exam and if you have to go back, go back at the end of that clinic and catch up and take the sticky note and it will refresh your memory as to what went on during that exam because a lot of times you forget. You forget the little details. I did them day to day and always at the end of the clinic. I never did it at the end of the day for the entire day. One-half of the day, I'd do in the morning catch up and then at the end of the day, catch up for that part of the day.

I never did agree with just putting them in a room and saying, I'll be right back with you and then doing the exam. I always like to sit down before I do an exam and talk to them and see what their problems are because you establish a rapport that way.

I learned that you're really not alone, though there are certainly other times when you felt that way but all of a sudden I thought, I'm not a student anymore. I don't have backup and I have to make a decision here that could help or hurt my patient. It was traumatic at the time. It was really good in the long run in that it taught me a lot when I had time to give it some introspection.

It is very important right off the bat, of going and building up a relationship with people in the ancillary services. Talk to the guys in Pharmacy. Talk to the people in lab.

Talk to the people in X-ray so they know you; so they have a face to go with this name and they understand where you're coming from. I think it is perfectly acceptable to go to somebody and say, I'm a brand new practitioner and I don't know what I may be ordering but I need somebody where I can call and say, What's the best diagnostic test for this? Can an x-ray help me? Do I want an ultrasound? There were hard lessons learned but there were really good lessons learned.

I was always looking for zebras and I think that's just part of being me. If they didn't perfectly fit my model of what the child with bronchitis was going to look like, then I was certain they had something worse. Over testing. I think that was probably the challenge. It's a challenge to go ahead and trust your gut that you think is probably right and that you can maybe try this therapy and bring them back for a follow-up in two weeks and see if what you did was right. If it wasn't then you can make changes rather than maybe jump into the big guns right away. You got somebody that you're pretty sure it's a virus. Then don't give them any antibiotics. Being able to stand on your guns and say, Your child doesn't need any antibiotics but certainly, if they get worse, come back.

Moms will be talking to you and one of the things they would always say, Nobody listens to me. Nobody believes me when I said my kid was sick. She had a kid with leukemia. She's been complaining about this child for months and no one took her seriously. Well, you know, I saw this kid for strep throat and she said, This kid looks pale to me. She didn't look pale to me. This is mom and she knows her child's complexion. I say, Well, okay. This has been going on — aches and pains and she's pale. Why don't we just do a CBC and see what comes back. And this kid ends up being a leukemic. Here's this mom saying, No one is listening to me. I always say listen to the parents. Always listen. They know that child much better than you ever would. So, listen to them. You will learn a lot. Trust them when they say that something is wrong.

If I had brand new graduates I'd send them places where they have a Family Practice residency. Each year we shrink and expand our roles. I also think they should have all new post-graduation residencies, so they can get their feet wet. One month in Ophthalmology, one month in Derm, one month in ER, two months on Surgery Service, two months in Internal Medicine, one month in Immunizations/Allergies, two months in GYN and Labor and Delivery, two months in Pediatrics, and then maybe a month in the ASF. One whole twelve month period. That would be the residency for that FNP. When I graduated that's what I did. I set up my own residency.

I would advise anyone going into that practitioner role, do it. Go in there with a positive attitude that you can do this but be ready. Be ready. And again, it depends on what facility you're in. It depends on what kind of clinic you're in. If you're in a slow clinic, don't jump out there in a busy clinic or don't jump out there without physician support. I mean true mentoring support. You've got to have another nurse practitioner who will mentor you.

You have to learn that medical model, that H&P and physical and all that stuff but you can't forget that nursing component. I think that's what makes us different from physician; that nursing, holistic component that a lot of practitioners lose because they got so hung up on the MD role.

You are a nurse first and if you are going to play junior doc — fine. But don't you lose that nursing, caring component. That's why patients come to you, not to the doc. Or that's why we can get patients to do things that a lot of physicians can't. I have patients I have helped them to manage their diabetes differently or their hypertension differently, just taking their meds differently.

You are prepared adequately and people out there recognize what a new graduate is because there are new graduate doctors. Everybody is a new grad. There is a certain understanding out there in medicine what a new grad is. The same in nursing. There's a certain understanding.

First, relax. You are well prepared. You will feel pretty good after two years. Three years seemed to be magic for me. After one year I felt pretty good. After two years, I felt very good and then now after three years, you know what you know and you know what you don't and you don't know everything.

Every single day, I think I learn something. There was a rare day when I'd go in and I was up to 28 to 34 patients a day and there'd be a rare day when you would go home and say I didn't really learn anything today that I didn't already know but that was a rare day. Usually, every single day, you picked something up.

In the military, we use Physician's Assistants. They were excellent and they taught me a lot. So, there are differences in all of us. There are GMOs, Family Practice Physicians, Internists, PAs, and the NPs. We all bring something to the profession of medicine, of diagnosing and treating and there is a place for all of us in the organization. I was well-respected by the PAs and they were respected by me and they taught me a lot.

As soon as I came back from my board exam, I said, Okay, I'm ready. Push me up. [shorter appointments] You have to experience that too. You have to be pushed. You have to fall behind and things like that and I think that everybody is going to be a little bit different and just in your class and I think part of that is going to be who they are as a basic individual. Some people just take their time.

A few things I learned from preceptors: always chart what you see, what you know, what you think it is. When you consult always say, Hey, this is _____, I'm a Family Nurse Practitioner. Physicians like to know whom they are speaking with because it is really embarrassing if you don't say that and down the road they think they are talking to a physician, it doesn't look good for you. People use their rank in the

military and I think it's fair that they know what level they're speaking with, so #1, they don't go over your head, and #2, they don't feel deceived or let down.

We all do the same things. I took charts home once. I never did that again. You learn to do your charts after every patient and then if you're falling behind, which is common your first couple of years out, it's very stressful to see those charts on your door and you're finishing up a chart and there's four people waiting for you in the lobby and it's stressful. And you have to learn how to deal with that. So, what I would do is take yellow stickies and quickly write down my diagnosis and what I prescribed and write down maybe some pertinent medical exam findings real quick. And I would stick the sticky on the chart and put it aside and go grab the next patient when I got caught up I'd write my record. I wouldn't go to lunch until my records were done for the morning.

I knew when I was going home, I was done. Whereas in those admin roles, you're never done. You always have to go home and work on an OPR or EPR or the schedule. But I knew I wasn't carrying a briefcase. I had enough experience to recognize the positive aspects of being a provider. Actually I liked being a senior person in the role after awhile because I think I offered a fresh perspective to a lot of people in the trenches.

You are still in the Nurse Corps. Even though you are a provider, people better understand that you're still a nurse and we need to bring our Chief Nurses up to snuff on who we are and what we're all about. When you become a provider, you're kind of out of the grips of the Chief Nurse, and a lot of people take that and run with it as freedom. You are now going to Prostaff. You're more under SGH side of the house, the providers side of the house and that's good. But when it comes time for you PRF to be written for promotion, when it comes time for you to PCS, those nurses are talking. You need to remember. Those Chief Nurses look at nurse providers as soon as they become a provider, they don't volunteer for things.

The challenge is for Nurse Practitioners out there to keep involved with nurses and nursing as well as learning the new role with providers and docs and the SGH.

Theme Cluster 7B: Paving the way for new practitioners

I really felt the burden of I ought to be really good. I felt I was paving the way for nurse practitioners because I was the first one at ____ AFB. So, I needed to be really good because there are going to be people behind me. The experience was good.

I just feel a sense of responsibility towards nursing and nurse practitioners and I don't know if that is shared by everybody and I'm going to say that it isn't but it is a sense of responsibility for me.

I had to get in there and prove myself and I tell you, I was pretty upset. I didn't think it was fair. So, I get up there and I went right in at 20 minute appointments because

the PAs, the docs, everybody was like Here comes another nurse practitioner. And, I got right in there and I had to prove myself and I did. It sounds like Oh go ahead, pat yourself on the back but that s not the reason I am sharing it with you. The reason is we all need to be thinking about the people behind us. You want those medical directors and you want those element chiefs to want the nurse practitioners and that s only going to happen if we get out there and work hard, lead by example, be good officers and take good care of our patients. If you go out there and you whine and you re selfish and you re not a team player , that s going to be particularly hard on the nurse practitioners in the program that have rank. I harbor a little resentment to people who are slackers and don t care about what I think is important and that s the profession.

Existential Themes

Our lived experiences and the structures of meanings (themes) in terms of which of these lived experiences can be described and interpreted constitute the immense complexity of the lifeworld (Van Manen, 1990, p 101). The lifeworlds of individuals differ because humans differ in how they live in the world. There are lifeworlds of the parent, of the child, and the researcher, thus it goes that the lifeworld of the nurse practitioner will have different qualities from that of a registered nurse or any other profession.

Van Manen (1990) identified four fundamental existential themes which he felt pervaded the lives of all human beings, regardless of their individual circumstances. They are lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relation (relationality or communality). Three of these existentials will be examined as they relate to the participants experiences. Lived time, lived other, and lived body were chosen because the nurse practitioners spoke often of experiences that related to these three existentials.

Van Manen (1990) writes, As I make something of myself I may reinterpret who I once was or who I now am (p 103). As the nurse practitioners began to experience

their new role, their picture of how they fit into the world, their new clinical world, changed drastically. And often times, these changes revolved around the concept of time. This is a combination of objective time (the clock) and subjective time (their perception). Many NPs spoke of their nursing experience in terms of years, 19 years nursing experience, 13 years as a nurse, 21 years . The years spent as a registered nurse were very important and a great source of pride for the NPs. It seemed to connect them to their new job and gave them a sense of confidence remembering their competence and experience as a registered nurse. Time became very objective as it related to the duration of appointment times. Many NPs were very concerned about seeing patients in small amounts of time, ie 20-minute vs 15-minute appointments . This was stressful to the NPs during their first year. Most of them felt they could not give quality care in such a short time frame.

Several NPs spoke of staying late in the clinic, resenting the technicians who left at 1630, playing catch-up through the day, and missing the lunch hour. The issues of time can be all-encompassing to a new nurse practitioner. There were several NPs who shared feelings of loss of autonomy and having no control over their schedule because they were told when to come to work, when to see patients, when to eat, and they would leave at the end of the day, only when their work was done or they felt, their responsibilities to the patients were completed. These are all aspects of time and Van Manen describes them as our temporal way of being in the world.

The second existential that was apparent in the NPs interviews was lived other or relationality. Van Manen (1990) describes this as the lived relation we maintain with others in the interpersonal space that we share with them. As we meet people we form

physical impressions of them and they become physically present to us. This allows us to transcend ourselves and develop relationships with others. Nurse practitioners, by their very profession, share numerous relationships with others; patients, physicians, families, supervisors, other NPs, and ancillary staff to mention a few. The military nurse practitioner has additional relationships in her world, the military structure and subsequent chain of command.

The participants in this study spoke with fervor about their preceptors and mentors. Some felt the need to not be too threatening, others shared a positive learning environment, and still others faced a distant, sometimes hostile preceptor. These preceptors shaped the NPs' experience during their first year. One NP even remarked, that the kind of transition NPs experience depends on the kind of mentor they had. That is extremely significant in that a relationship with a mentor or preceptor can impact that first year experience to such a degree.

Some NPs had to adjust to new relationships with the Nurse Corps as a whole, the Chief Nurse and with fellow nurses, as they entered the arena of being a provider. To most of the participants their place in the nursing world was rock-solid before, as many of them had numerous years of nursing experience. They expressed feelings of not fitting in this world as readily as they moved into their new role and missed this sense of belonging.

The relationships that NPs had with their patients was extremely important and allowed them to see and really feel where they fit into their new world. Many of them felt good about themselves after receiving positive feedback from their patients. This seemed to replenish their energy and fuel their new identity. However, patient care was

daunting to these new NPs and many expressed fear about their new responsibilities, sharing their experiences of having nightmares, worrying about patients, and fear of coming to work in the morning. Human beings often search in this experience of other, the social, for a sense of purpose in life, meaningfulness, and grounds for living (Van Manen, 1990).

Lived body refers to the phenomenological fact that we are always bodily in the world. Van Manen writes, in our physical or bodily presence we both reveal something about ourselves and we always conceal something at the same time. In a military setting when these nurse practitioners wore their uniforms with their rank on their shoulders, they spoke of what they revealed about themselves to their peers and patients. Rank became an issue to these new graduates because they felt people expected a certain level of expertise from them based on their rank, despite the fact they were new graduates. Some participants spoke of their struggle moving from an expert level back to a novice level in their new career field. One NP said she went from being an expert to just not being. By losing her expertise this NP was saying she had lost a great deal more of herself and how she bodily fit into her new world.

The four existentials mentioned can be differentiated but not separated. Together they form an intricate unity to which we relate our lived world. The researcher chose three of these existentials in their differentiated aspects, but realized the other existential, lived space, also exists in the life of a new nurse practitioner. One existential always calls forth the other aspects (Van Manen, 1990). The nurse practitioners interviewed for this research study shared rich experiences of their lives during their first year of clinical

practice. They gave us a true sense of what it was like fitting into their new world, both the positive and the negative aspects of their first year experience.

CHAPTER V: SUMMARY

Introduction

This chapter presents a discussion of the research findings. Integration of the findings across the theme categories and theme clusters are examined and current literature is reviewed. The significance for nursing, recommendations for further study, and research conclusions are also discussed.

Integration of Findings

The purpose of this research was to describe the experiences of military nurse practitioners during their first year of clinical practice. The research method of phenomenology was used because it best describes peoples experience as it is lived. Phenomenology focuses on gaining a deeper understanding of the meaning of our everyday experiences (Van Manen, 1990). The researcher interviewed six military nurse practitioners about daily experiences in their clinical settings. The interviews were transcribed and analyzed using strategies suggested by Scannel-Desch (1992) and Marshall and Rossman (1989). Van Manen (1990). The described experiences revealed 7 themes and 15 theme clusters. Van Manen s lifeworld existentials of lived time, lived body, and lived relationship were used to further develop a deeper understanding of the nurse practitioners experiences.

Benner (1994) describes a process of development from novice to expert and suggests that expertise is developed only when the clinician tests and refines theoretical and practical knowledge in actual clinical situations. All of the participants felt they had reached that expert level many years ago in their nursing careers and some were disheartened to find themselves at the novice level again in their new advanced practice

nursing careers. One powerful statement I think the biggest part of the adjustment was just from being an expert to not being describes the depth of this phenomenon. Yet these participants leaned heavily on their nursing instincts and expertise to guide them through some difficult situations. They knew the skills and knowledge learned in their NP programs were greatly enhanced by the years they spent at the patients bedside. They frequently took advantage of this experience, applying it to their new role.

Another significant area of concern expressed by the participants was the wide discrepancy between their expectation of an NP's scope of practice and the reality of clinical practice. The NPs described various degrees of this culture shock. One NP felt completely unprepared to precept new NP students in her third month of practice, but she managed to turn it into a positive experience by learning from them as well as teaching them. Another was disillusioned when she realized she was functioning like one of the residents, not as the health promoter she had dreamed of becoming. Many of the NPs realized they were seeing much more complex patients than they had anticipated and expressed fear of being in "over their heads". They frequently worried during off-duty hours whether the health care decisions they had made were the best ones for the patient. Busen & Jones (1995) state the goals of the educational preparation of NPs must include greater role clarity and a decrease in conflict by more clearly defining the NP scope of practice for students.

Several of the NPs cherished their role as an advanced practice nurse, advising NPs who come behind them to always remember you are still a nurse. They took pride in their holistic approach to patient care and fought successfully to maintain longer appointment times so they could spend time educating their patients. They faced

numerous barriers but struggled to hold onto their idea of excellent nursing care as the foundation for a successful NP career. Unfortunately, they often faced others perceptions that they were now 'out of a nursing role' and into a provider role.

Before NPs and PAs came to the forefront of health care, the word provider was rarely, if ever used. Health care providers were simply called physicians or doctors, because they were most visible to the public. Using the word provider is now deemed politically correct and includes physicians, PAs, and NPs. To some nurses, this may raise the question of, aren't all nurses providers? Nurses at all levels provide patient care and facilitate healing. However, several of the NPs in this study expressed they somehow crossed over from being a nurse to a provider, and this became a sensitive issue to their nursing peers as well.

One NP described feelings of being ostracized and cut off from the Nurse Corps during her first few months of practice. This raises the question Is there a hierarchy within the nursing profession? Many of our military NPs wear multiple hats, either that of a head nurse or an administrator. Several described a see-saw effect moving back and forth between the roles. One nurse practitioner was asked by a patient if she was a nurse practitioner or just a nurse. Another NP unwittingly stated she knew her preceptor back when she was a nurse. In the military, many senior Nurse Corps officers view NPs as non-nurses and do not consider them members of the health care team (Chung-Park, 1998). Furthermore, Navy NPs are assigned to the Medical Department, not to nursing service.

Another question raised is which holds more value for the NP and for the public, that of a nurse writing prescriptions for medications or that of a nurse administering the

medications at the bedside? The registered nurse and the advanced practice nurse hold different roles, but does the level of education correlate with a different level of power that encompass each role? These participants struggled with similar questions during their first year of practice, as they made attempts to fit into others' expectations of themselves while simultaneously living up to their own.

Context of the Literature

The literature was reviewed for a second time after the interviews were completed. The themes that emerged from this study are supported in the literature and deepen insight to the unique challenges of a military nurse practitioner.

Perceptions of NP role

The perceptions of the Navy NP's roles by commanding officers (COs), directors of nursing services (DNSs), physicians and NPs, and the level of job satisfaction among Navy NPs was discussed by Chung-Park (1998). A total of 907 questionnaires investigating the NP role and job satisfaction were mailed, with a 50% response rate. The results highlighted the different perceptions among the groups. The overall perception of the NP role was favorable. The DNSs focused more on the NP's administrative and leadership role, whereas the COs perceived the NPs' role as more clinical. Chung-Park suggests that this difference could place the NP in role-perception conflict between administrative and clinical responsibilities, causing tension in the work environment.

In general, levels of job satisfaction varied from one setting to another based on the amount of autonomy as well as acceptance and recognition by others. The participants in this study spoke of these issues as they made their role transition. Several of the

participants, who were dual-hatted in management and clinical practice, said that splitting their time and focus was the biggest adjustment they made. Despite problems and dissatisfaction, many Navy NPs in Chung-Park's study reported overall satisfaction with their jobs.

Mentoring and precepting

Mentoring and preceptorship issues emerged as a theme for all the nurse practitioners in this study. In an earlier study Sloand, Feroli, Bearss, and Beecher (1998) reported that the complex and challenging job of clinical preceptorship demands that the preceptor be a wise time manager, an excellent clinician, an understanding teacher, a gracious hostess, and a caring professional. All of the NPs in this study had a rich story to share about their preceptor and one participant identified it as the strongest indicator of how smooth or how rocky the transition could potentially be for others.

In a related study of nursing, Bittner and Anderson (1998) created a precepting map for RN-to-BSN students. These students were assigned a preceptor based on the Benner's Novice to Expert Model. Clinical placement is then tailored to enhance the experience for students, faculty, and preceptors. Collaborative task forces were assembled and potential preceptors attended specific workshops to familiarize them with adult learning theories. Lastly, a precepting model was developed. Before the RN student and the preceptor were matched, the researchers proposed six months of preparation to ensure the best possible match between the level of clinical expertise on the part of the student and the preceptor's readiness to tackle this responsibility. The authors proposed that their model is applicable to multiple levels of nursing students graduating from undergraduate or graduate programs.

Some of the comments the participants in this study made about their preceptors were, she took me under her wing, she was not willing to share, I had no one to mentor me, let's keep you protected, you're at the mercy of who you work with, he didn't know how to be a preceptor, and she was not supportive. Many of the comments and experiences with preceptors were still vivid ones, although one NP knew her preceptor from a previous assignment and described this as a positive experience. This is an area of concern to new NPs and improving the process of choosing preceptors, as Bittner and Anderson suggest, may improve those first crucial months of an NPs experience.

Ecklund (1998) supported this stance and expands on it as well when she wrote, mentoring as a relationship between a novice and an expert can help promote stability in nursing (p 13). The author sampled 230 critical care nurses using a survey instrument and measured job satisfaction in mentored and non-mentored nurses. The data suggested that support offered by mentors is highly valued by critical care nurses, as is the sharing of knowledge and expertise. Participants were asked to choose an adjective to describe their mentor. 'Supportive' and 'knowledgeable' were the top two responses listed by both groups. Regardless of the kind of transition one is making, preceptorship and mentoring are different concepts but clearly related. A new nurse will benefit from the support of a preceptor and a mentor.

NPs job satisfaction

In February 1999, The United States Army assessed the job satisfaction of their NPs, physicians, and PAs (Byers, Byers, Mays, & Mark, 1999). Questionnaires on job satisfaction and other practice style variables were completed by 26 physicians, 19 nurse

practitioners, and 13 physician assistants. Nurse practitioners were most satisfied with helping people, engaging in direct client care, providing high-quality care, having a variety of work and having independence in clinical matters. They were most dissatisfied with work setting issues; such as low salary, time pressures, organizational policies, and lack of opportunity for career advancement. Regardless of provider type, the perceived level of autonomy in clinical matters was the best predictor of job satisfaction.

Autonomy

Autonomy as a concept was discussed by several of the participants in this study. Some felt overwhelmed by having too much perceived autonomy in their practice, oftentimes wishing they had someone looking over their shoulder more frequently. However, one participant described her biggest adjustment as being the "loss of autonomy" as it related to her schedule. Each NP defines autonomy differently as it relates to her. The participants in this study expressed autonomy on a continuum. Too much autonomy was perceived as abandonment and too little autonomy was viewed as too controlling.

Much of the civilian nurse practitioner literature discusses how civilian NPs are fighting to increase their autonomy. In Mosby's Dictionary (1994) autonomy is defined as "the quality of having the ability or tendency to function independently" (p. 153). In contrast to their civilian counterparts, most of the military NPs interviewed described a perceived excess of autonomy. One described a particularly difficult pediatric case and felt she had no one to turn to, "I truly felt in this huge pediatric clinic, with 32 physicians, that I was all alone." Another felt very isolated and described a "total independent

practice with little or no available physician back-up. Military NPs were certainly satisfied with the level of autonomy in their daily practice.

Black, Dooley, Hersh, O Keefe, and Patrick (1998) state that the NPs must internalize autonomy in order to gain acceptance as true professionals by health care consumers and providers. Their study was designed to determine by survey, whether NP students' expectations of future professional autonomy was grounded in reality. Participants were limited to NP students in their final year of a master's program and certified NPs with a master's degree. The findings indicated the practicing NPs experienced a greater sense of autonomy than student nurse practitioners perceived. Recommendations were made to continue related research to assist schools of nursing in developing reality-based curricula for nurse practitioner programs. To enhance readiness, master's programs should provide NP mentors to enhance the role modeling of autonomous behaviors (Black et al., 1998).

Commitment to the Study and Interview

The nurse practitioners interviewed were very willing to share their experiences with the researcher. Most were committed to the profession of nursing and wished to facilitate future NPs' transition into the advanced role by sharing their personal stories. They provided information that was important to them and offered an accurate portrayal of their role. The participants were particularly eager to offer specific advice to future NPs, thus beginning the mentoring process many of them deemed vital to their success. They believed sharing their experiences would benefit new NPs and other health professionals who are making a transition into a new and challenging role.

Significance to Nursing

The findings of this study demonstrate several areas of significance for nursing. There have been many studies in the area of role transition issues of the civilian nurse practitioner, but very few studies focused on the experience of the military nurse practitioner during the first year of clinical practice. The military is committed to primary care and health promotion and nurse practitioners will continue to play a vital role in this unique mission. NPs face numerous challenges during their transition to an advanced practice nurse and acknowledging these challenges is the first step in facilitating a smoother transition in the future. Identifying the needs and understanding the experiences they shared is significant to nursing education, nursing research, and future preceptors in the clinical setting. Particular aspects of the experience such as understanding the NP role and scope of practice, dual-hatted challenges, rank issues, and autonomy adjustments clarify the experience and provide opportunities to prepare military NPs for their initial year of practice.

Summary of the Study

The purpose of this research was to describe the experiences of military nurse practitioners during their first year of clinical practice. The study was undertaken because there was little known about the first year of a nurse practitioner's career in the military. Increasing the awareness of NPs' unique challenges will contribute to nursing knowledge and clinical practice.

This study is significant to the nursing profession because nurse practitioners will continue to play an important role in primary health care. Military nurse practitioners will also be deployed in humanitarian operations in the future and understanding their

peacetime role will enhance their role during deployment. Ensuring a healthy and positive role transition during their first year of clinical practice will strengthen the military health care mission.

Recommendations

The recommendations for further research include examining the specific role of the Family Nurse Practitioner, as this is the newest NP subspecialty. This study interviewed NPs regardless of their certification. Thus, their challenges and experiences were at times unique. Additionally, it may be helpful to examine the NP role from the perspective of physicians, since NPs and physicians practice in a collaborative manner.

There are very few studies regarding a military NPs initial year of practice and a replication of this study would be enlightening. The researcher did not interview Navy NPs, but in future studies, it would be beneficial to include TriService experiences. It is vitally important to continue studying the NPs transition into the role, as nurse practitioners will continue to be at the forefront of military healthcare. A smooth and healthy first-year transition will enhance overall NP job performance and satisfaction, thus ensuring excellence in patient care and a mission-ready military force.

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APPENDIX A



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON, DC

27 JUL 1999

MEMORANDUM FOR CAPTAIN JULIE M. BOSCH
GRADUATE SCHOOL OF NURSING
UNIFORMED SERVICES UNIVERSITY
OF THE HEALTH SCIENCES

FROM: HQ USAF/SGX
110 Luke Avenue, Room 400
Bolling AFB, DC 20332-7050

SUBJECT: Data Collection Request

This is in response to your request for official permission to speak with six to ten military nurse practitioners as part of your qualitative research study involving their experiences during their first year of practice.

I support your request to contact Air Force nurse practitioners to discuss their transitional experiences during the first year of advanced clinical practice. Once you have received approval from the Institutional Review Board to begin data collection for this study, you may contact the nurses directly to explain the study and to invite them to participate.

Understanding the scope of this phenomenon will be of tremendous help in developing course content and learning activities for this important role transition. The increased demands for productivity and the multiple stresses of clinical practice in diverse settings confirms the significance of this effort. It is important that new nurse practitioners be able to function in their full capacity as soon as possible? and this study promises to identify some of the key issues. This will be a unique contribution to the Air Force Medical Service as we continue to design optimal health care delivery models.

A handwritten signature in black ink, appearing to read "Linda J. Stierle", is positioned above the typed name.

LINDA J. STIERLE, Brig Gen, USAF, NC
Director, Medical Readiness and Nursing Services
Office of the Surgeon General

APPENDIX B



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5199 LEESBURG PIKE
FALLS CHURCH VA 22041-3258

DASG-AN

23 August 1999

MEMORANDUM FOR Captain Julie M. Bosch, Graduate School of Nursing,
Uniformed Services University of the Health
Sciences

SUBJECT: Data Collection Request

1. This memorandum is to concur with your request to speak with six to ten Army nurse practitioners as part of your research study.
2. I understand the Institutional Review Board has approved your study. Therefore, you may contact the Army nurses directly to explain the study and invite them to participate.
3. Please contact LTC Susanne Clark at (703) 806-0644 for any questions. I look forward to reading the results of your study!

BETTYE H. SIMMONS
Brigadier General
Chief, Army Nurse Corps

APPENDIX C



UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES
F. EDWARD HEBERT SCHOOL OF MEDICINE
4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4799



May 27, 1999

MEMORANDUM FOR JULIE M. BOSCH, GRADUATE SCHOOL OF NURSING

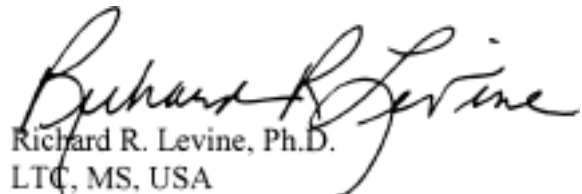
SUBJECT: IRB Approval of Protocol **T061AI-01** for Human Subject Use

Your research protocol entitled ***“Experience of Military Nurse Practitioners During 1st Year Clinical Practice,”*** was reviewed and approved for execution on 5/27/99 as an **exempt** human subject use study under the provisions of 32 CFR 219.101 (b)(2). This approval will be reported to the full IRB scheduled to meet on June 10, 1999.

The purpose of this study is to explore and describe the transitional experience of the military nurse practitioner during the first year of practice. Six to ten military advanced practice nurses (APNs) will be interviewed regarding their personal experiences as a first year nurse practitioner. The IRB understands that while all interviews will be recorded, no subject identifying or personally sensitive information will be recorded as part of this study. *Additionally, to further enhance the protection of subject confidentiality, the IRB requires that all interview recordings be destroyed at the conclusion of the study. This protection should be included in the “Privacy and Confidentiality” section of your informed consent document as well.*

Once your informed consent document has been updated, please provide this office with a clean copy of the revised informed consent document on USUHS letterhead for approval. Once approved, photocopies of the stamped and dated consent form should be used to obtain consent from all subjects. **Additionally, you are also required to submit a copy of the Air Force approval for this study once it is received, to complete our files.**

Please notify this office of any amendments you wish to propose and of any untoward incidents which may occur in the conduct of this project. If you have any questions regarding human volunteers, please call me at 301-295-3303.


Richard R. Levine, Ph.D.
LTC, MS, USA
Director, Research Programs and
Executive Secretary, IRB

Cc: Director, Grants Administration

APPENDIX D



UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

4301 JONES BRIDGE ROAD
BETHESDA, MARYLAND 20814-4799
INFORMED CONSENT FORM



Research Study

Experience of Military Nurse Practitioners During Their First Year of Practice

INTRODUCTION

You are being asked to take part in a research study because you are a recent nurse practitioner graduate. This consent form provides information about the study. Once you understand the study you will be asked to sign this form if you want to take part. Your decision to participate is voluntary.

PURPOSE OF THE STUDY

The Graduate School of Nursing of the Uniformed Services University of the Health Sciences and Capt Julie M. Bosch are conducting a research study to describe the experience of military nurse practitioners during their first year of practice. You will be one of approximately eight nurse practitioners in this study. You will be interviewed by the researcher. This interview will be audiotaped and last approximately 30-60 minutes. You will be asked a core question with additional follow-up questions aimed at clarifying your responses. The questions will focus on your experience as an advanced practice nurse during your first year of clinical practice.

PRIVACY AND CONFIDENTIALITY

All information you provide as a part of this study will be confidential and will be protected to the fullest extent of the law. Information will be kept private and accessible only to those persons directly involved in conducting this study. All interview material will be kept in a restricted area or locked cabinet while not in use and all interview recordings will be destroyed at the conclusion of the study. After the interview, no identifying data will be maintained. Any future reports on this study will not use your name or identify you personally.

RISKS AND BENEFITS

There are no physical risks from participating in the study. You may not personally benefit from this study. However the study may contribute to a better understanding of the experience of the new nurse practitioner during their first year of clinical practice.

QUESTIONS

If you have any questions about this research study, you should contact Capt Julie Bosch at (301)-295-1001 during the workday or (301) 682-6650 during the evening hours. If you have any questions about your rights as a research subject, you should call



Handwritten signature and date:
12 July 99

the Director of Research Programs in the Office of Research at the Uniformed Services University of the Health Sciences at (301)-295-3303. This person is your representative and has no connection to the researcher conducting the study.

SIGNATURES

By signing this consent form you are agreeing that the study has been explained to you and that you understand. You are signing that you agree to take part in this study. You will be given a copy of this consent form.

DATE

SIGNATURE OF PARTICIPANT

PARTICIPANT'S PRINTED NAME

INVESTIGATOR STATEMENT

I certify that the research study has been explained to the above individual and that the individual understands the purpose and the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered.

DATE

SIGNATURE OF INVESTIGATOR

INVESTIGATOR'S PRINTED NAME

A circular stamp containing a handwritten signature and the date "12 July 93".

APPENDIX F
Thesis Approval Form

EXPERIENCE OF MILITARY NURSE PRACTITIONERS DURING THEIR FIRST
YEAR OF PRACTICE

Capt Julie M. Bosch

APPROVED:

<u>D. Martha Turner RN, PhD</u>	<u>8 Dec 99</u>
Chair	Date
<u>Patricia C. McMillen, JD, MS, CWS, CWS</u>	<u>8 Dec 1999</u>
Member	Date
<u>Diane Smith, MS, CWS</u>	<u>8 Dec 99</u>
Member	Date

APPROVED:

<u>F.G. Abdellah</u>	<u>4-7-00</u>
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F.G. Abdellah, Ed.D., Sc.D., RN, FAAN
Dean

Date